



Changes apply to:
 Medical Only
 Dental Only
 Medical and Dental

MEDICAL & DENTAL CHANGE FORM

PLEASE PRINT

Social Security #	Medical Member #	Dental Member #
Employee Name	Employer Name	Employee Division

NAME OR ADDRESS CHANGES

Name	Telephone #	
Address		
City	State	Zip Code

REASON & EFFECTIVE DATE OF CHANGE

Employee Coverage End Date _____	Reason _____
Employee/Spouse/Dependent Change	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____
Comments:	
Please attach documentation such as court documents, Certificate of Creditable Coverage, etc.	

List eligible Dependents to be covered/terminated, oldest to youngest. A Dependent is a person who is: 1) the Subscriber's legal spouse; 2) a child who is a United States citizen or legal resident of the United States and a) a son or daughter of the Subscriber regardless of support level, or b) a step-child, child subject to legal guardianship, grandchild or other blood relative who depends on the Subscriber for more than 50% of total support; 3) any child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract. List last name if different from employee.

Dependent Name _____ Relationship _____
Social Security # _____ Date of Birth _____ Gender: MALE FEMALE
Dependent Address _____
Medical: Add Delete Effective Date _____ **Dental:** Add Delete Effective Date _____

Dependent Name _____ Relationship _____
Social Security # _____ Date of Birth _____ Gender: MALE FEMALE
Dependent Address _____
Medical: Add Delete Effective Date _____ **Dental:** Add Delete Effective Date _____

Dependent Name _____ Relationship _____
Social Security # _____ Date of Birth _____ Gender: MALE FEMALE
Dependent Address _____
Medical: Add Delete Effective Date _____ **Dental:** Add Delete Effective Date _____

COORDINATION OF BENEFITS INFORMATION:	Have you ever been a PHP member? <input type="checkbox"/> Y <input type="checkbox"/> N
On the date that Coverage is to be effective, will you or your Dependent(s) have any other Coverage? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, complete the following:
Health Plan Name _____	Policy/Group/ID # _____
Dental Plan Name _____	Policy/Group/ID # _____
Claims Address/Phone # _____	Effective Date _____ Termination Date _____
Policyholder's Name _____	Policyholder's Social Security # _____
Covered Individuals _____	Policyholder's Birth Date _____
Employer through which coverage is held _____	<input type="checkbox"/> Medicare Plan A (Hospital only) <input type="checkbox"/> A & B (Hospital & Medical)

I (WE) HEREBY REPRESENT that all statements and answers herein are full, complete and true. These statements and answers are to be considered as the basis for Coverage under the Plan. I understand that (1) this form constitutes a part of the Plan Contract and (2) no Coverage will be effective until the date specified by the Plan.

EMPLOYEE SIGNATURE: _____ Date: _____

EMPLOYER SIGNATURE: _____ Date: _____